Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

Pedro Nosnik, MD, PA
4100 W. 15th St., Ste. 218
Plano, TX 75093

MFDR Tracking #: M4-08-3460-01

DWC C

Injured Em

Date of

Employer c.

Insurance Car

Respondent Name and Box #:

Dallas National Insurance Co.
Rep. Box #: 20

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as listed on the Table of Disputed Services: "No EOB or payment received copy of computer log for timely filing."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $7694
3. CMS 1500s
4. Submission documentation

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Response not received

Principle Documentation:

1. N/A

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
05/29/07	99213 ($61.55 x 125%)	No EOB	1, 2, 3	$76.94
Total Due:				$76.94

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. Neither party submitted EOBs. Per Division Rule at 28 Texas Administrative Code Section 133.307(c)(2)(B) the Requestor has submitted convincing evidence of the initial bill submission and the carrier receipt of the request for an EOB.
2. Per Division Rule at 28 Texas Administrative Code Section 134.202(b) & (c)(1) reimbursement is recommended.

3. Per review of Box 32 on CMS-1500, zip code 75220 is located in Dallas County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

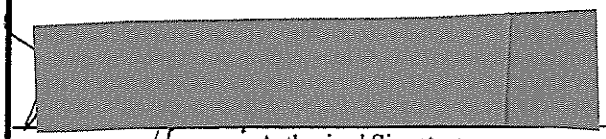
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 133.307, 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

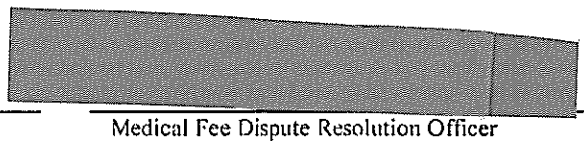
PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $76.94 plus applicable accrued interest per Division Rule 134.130

ORDER:



Authorized Signature



Medical Fee Dispute Resolution Officer

March 27, 2008
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.